# Highlights of this issue

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## VIOLENCE: VICTIMS AND OFFENDERS

Asylum seekers have often been victims of violence. They are interviewed by the Home Office on arrival in the UK, and their disclosure of violence during this interview may be limited or absent. This is frequently revealed during subsequent interviews, when it can often be viewed sceptically. Data from Bögner and colleagues (pp. 75–81) suggest that guilt or shame may preclude victims of sexual violence from disclosing such personal information during these initial interviews. These victims also had higher levels of symptoms related to post-traumatic stress disorder. The authors suggest that late disclosure should not be assumed to reflect a fabricated asylum claim and there may be a need for more sensitive procedures during the initial assessment. An editorial by Herlihy & Turner (pp. 3–4) addresses the contemporary findings examining the relationship between memory and trauma, and how this may aid the assessment of victims of violence. The long-term outcome of patients discharged from medium secure care is relatively poor, with increased mortality, half of the patients being reconvicted and 38% readmitted to secure care. Davies *et al* (pp. 70–74) suggest that community teams taking over the care of these individuals need to remain vigilant to the these risks over a long period of time. They also note that information on risk needs to be communicated effectively across the increasing number of community teams caring for these individuals over time.

## PATIENT CHOICE AND OPIOID DEPENDENCE

Increasing patient choice is expected to deliver better and more appropriate services. Samele and colleagues (pp. 1–2) describe the framework being developed for increased choice within mental health, focusing on supporting life choices, engagement with services, and choice in assessment and treatment. They highlight the difficulties applying these approaches to psychiatry, where the choices can be very limited for patients assessed as being at risk. Similarly, resource issues may also limit the fit between patients' wishes and the services that may be available. They conclude that the challenges inherent in offering choice to service users should not preclude its application to psychiatry. One area where patient choice is especially relevant is in the field of addiction. Offering heroin rather than methadone has been suggested to be effective in severe dependence or where methadone maintenance has not been of benefit. Haasen *et al* (pp. 55–62) demonstrate that heroin-assisted treatment was superior to methadone in terms of improved health and decreased illicit drug use. More heroin-assisted participants were retained in the study, although they suffered from a significantly increased rate of serious adverse effects. They suggest that heroin-assisted treatment may fulfil a useful role in treatment resistance. The neural basis of craving for drugs is of obvious interest in addictive disorders. Williams *et al* (pp. 63–69) used positron emission tomography receptor imaging to demonstrate that there is an increased availability of opioid receptors in people with opioid dependence during early abstinence. Intriguingly, similar findings have been reported in alcohol and cocaine dependence, raising the issue that the opiate system may play a central role in addiction.

## MIND, BODY AND SOUL IN PSYCHOSIS RESEARCH

Thinking about others in terms of their mental states, also called mentalising, has been shown to be dysfunctional in schizophrenia. A meta-analysis of research findings in this area by Sprong *et al* (pp. 5–13) demonstrates that this is a robust effect, which is independent of differences in age, IQ and gender. Patients with more prominent symptoms related to disorganisation were more impaired on mentalising tasks, and the differences were also present in patients in remission. The authors discuss ways of extending this research to examine the relationships with social functioning and other relevant disorders such as autism. Most patients with a diagnosis of psychotic illness are treated with an antipsychotic medication. Mackin *et al* (pp. 23–29) report that, regardless of diagnosis, patients treated with antipsychotic medication have an excess of metabolic dysfunction and increased risk for cardiovascular disease. They emphasise the need for physical health assessment and clarity in the responsibility for physical health in patients with mental illness. Second-generation antipsychotic medications have been suggested to be more cost-effective, mostly secondary to perceived improvements in quality of life. Contrary to this view, Davies *et al* (pp. 14–22) demonstrate that conventional antipsychotic medication may be more cost-effective in patients with a diagnosis of schizophrenia, with an improvement in quality of life measures. They suggest that careful prescribing of first-generation agents is cost-effective. These authors note this is the first non-commercially funded study examining routine practice. Following on from this statement, Tungaraza & Poole (pp. 82–83) found that having a drug company employee as an author on a research paper is associated with a propensity for the study to report positive findings, eliciting a greater effect than commercial funding alone.

## SELF-HARM AND DEPRESSION IN PREGNANCY

Against the background of an increasing rate of self-harm among young people, Young *et al* (p. 44–49) found that young people outside the labour market, those who were unemployed, sick or not in full-time education, were the most likely to be engaged in chronic self-harm and actively trying to kill themselves. They suggest that targeting social causes may be more useful than biomedical intervention in this group. Depressive illness during pregnancy may have an impact on birth weight at term. A large longitudinal study by Evans *et al* (pp. 84–85) did not support this hypothesis, showing that there was no significant association once the effects of health-related behaviours such as smoking had been adjusted for.



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